SPORTS MEDICINE, ARTHRITIS,
& JOINT REPLACEMENT

Sanaz Hariri, MD
ORTHOPEDIC SURGEON

800 Pollard Road, Building C
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tel 408.871.1800 fax 408.871.2800
www.drsanaz.com

NEW PATIENT QUESTIONNAIRE

** Some of this information is required by the CMS (Centers for Medicare and Medicaid Services). Your demographic answers will never affect your care.*

Today's Date:_____ **Date of Birth:_____
First Name:_____ Middle Name:_____
Last Name:_____
** ☐ Male ☐ Female
**Primary Language: ☐ English ☐ Spanish ☐ Chinese
☐ Farsi ☐ Other _____

**Race: ☐ White ☐ Black/African-American ☐ Asian
☐ American Indian/Eskimo ☐ Pacific Islander
☐ Other _____

** Ethnicity: ☐ non-Hispanic ☐ Hispanic
HOME ADDRESS:

_____
Street Address

_____
City State Zip Code

Cell Phone #: _____ Home Phone #: _____
**Email Address (prefer your "forever" address): _____
Primary Care Physician: _____
Who Referred You to Dr. Hariri? _____
Reason for today's visit: _____
Primary Insurance: _____
Secondary Insurance: _____
Subscriber Name: _____ DOB: _____
Subscriber Relationship to Patient: _____
Do you have an Advanced Care Plan? ☐ Yes, approximate date: _____ ☐ No
Occupation: _____ Employer: :_____
Work Phone #:_____
If you are disabled: ☐ Temporary ☐ Permanent

Emergency Contact Name: _____
Relation to you: _____
Emergency Contact Phone Number: _____
Pharmacy Name, Street Name, and City
_____

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PAST MEDICAL HISTORY

☐Cancer: (Type and Treatment) _____	MUSCULOSKELETAL ☐Arthritis ☐Osteopenia/Osteoporosis
CARDIOVASCULAR ☐High Blood Pressure ☐High Cholesterol ☐Stroke/CVA ☐MI/heart attack ☐Vascular Disease ☐Atrial Fibrillation ☐Check if you have a Pacemaker ☐Check if you have a Defibrillator ☐Heart Problems: What kind? _____	INFECTION/IMMUNOLOGIC ☐Hepatitis ☐Tuberculosis (TB) ☐Immune Disorder ☐Lupus ☐Psoriasis ☐Rheumatoid Arthritis ☐Recurrent urinary tract infections
ENDOCRINE ☐Thyroid Disease ☐Diabetes ☐ Insulin Dependent	GI/GU ☐Kidney Disease ☐Liver Disease ☐Stomach Ulcers ☐Gastric Reflux/GERD
NEUROLOGIC ☐Multiple Sclerosis ☐Epilepsy/Seizures ☐Parkinson's ☐Alzheimer's ☐Drug Abuse/Alcohol Dependence	RESPIRATORY ☐Asthma ☐Bronchitis/Emphysema ☐Pneumonia
BLOOD DISORDER ☐Anemia ☐Bleeding Disorder ☐History of blood clots (e.g. pulmonary embolism and/or DVT)	OTHER CONDITIONS: _____ _____

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List previous hospitalizations, major surgeries, serious injuries and approximate dates:
☐ No history of surgeries or hospitalizations

Surgery/Injury/Hospitalization Date

_____
_____
_____
_____

MEDICATIONS: List all medications you are taking and dosages (prescription and all over-the-counter drugs):
☐ No medications

Medication Dosage (e.g. mg) Times/day

_____
_____
_____

Do you take Coumadin? ☐ No ☐ Yes: Dosage _____
Do you take Aspirin? ☐ No ☐ Yes: Dosage _____

ALLERGIES - List medication, food, latex and environmental allergies and describe reaction(s):
☐ No known drug allergies

Allergen Reaction

_____
_____
_____

FAMILY HISTORY
List any health problems in your immediate family:

	Age	Medical Problems	If Deceased: Cause & Age at Death
Father			
Mother			
Siblings			
Children			

Is there a family history of clotting disorders, bleeding disorders, or anesthesia complications: ☐ Yes ☐ No
- If yes, please explain: _____

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SOCIAL HISTORY

**Do you smoke? ☐ Currently: Pack(s) per day _____ How many years: _____
☐ Quit: How many years: _____
☐ Never smoked

**Have you had an alcoholic beverage in the last year: ☐ Yes ☐ No
IF YES, in the last year:
How often do you drink? ☐ monthly or less ☐ 2-4 times/month
☐ 2-3 times/week ☐ 4 or more times a week
When you drink, how many drinks do you have on a typical day: _____
How often did you have 6 or more drinks on one occasion in the last year:
☐Never ☐Less than monthly ☐Monthly ☐Weekly ☐ Daily or almost daily

☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
Who currently lives at home with you?_____
Do you live in a: ☐house ☐condo
☐assisted living facility ☐nursing home

REVIEW OF SYSTEM

Do you presently have any problems or symptoms in for following areas?

CONSTITUTIONAL ☐recent unexplained weight loss ☐recurrent fever, chills, &/or sweats ☐fatigue	BLOOD DISORDERS ☐easy bruising ☐frequent bleeding ☐enlarged lymph nodes
EYES/EARS/NOSE/THROAT ☐change in vision ☐change in hearing ☐recent nose bleeds ☐chronic sinus problems	ENDOCRINE ☐heat or cold intolerance ☐excess thirst or urination ☐thyroid problems
RESPIRATORY ☐asthma or wheezing ☐coughing up blood ☐chronic cough ☐pneumonia	MUSCULOSKELETAL ☐weakness in muscles or joints ☐difficulty walking ☐back pain ☐pain radiating down legs
CARDIOVASCULAR ☐heart trouble or heart attack ☐chest pain or angina ☐shortness of breath ☐palpitations ☐swelling of feet, ankles, or hands ☐blood clots	NEUROLOGIC ☐headaches ☐numbness or tingling sensations ☐weakness or paralysis ☐convulsions or seizures ☐change in memory or concentration

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GASTROINTESTINAL ☐severe heartburn ☐bleeding ulcers ☐constipation ☐black or bloody stools	PSYCHIATRIC ☐anxiety/ nervousness ☐memory loss or confusion ☐depression ☐difficulty sleeping
GENITOURINARY ☐blood in urine ☐burning with urination ☐change in force of stream when urinating ☐sexually transmitted disease	SKIN ☐non-healing wounds or ulcers ☐change in hair or nails ☐changing moles ☐skin infections
WOMEN ☐pain/problems with periods ☐abnormal uterine bleeding	IMMUNOLOGIC ☐low resistance to infection

OTHER MEDICAL PROBLEMS: _____
_____

PATIENT ACKNOWLEDGEMENTS

I have reviewed this form and certify that the responses are correct to the best of my knowledge.
I understand that Dr. Hariri will bill insurances for which she is a participating provider. I am liable for expenses incurred that are not covered under my insurance plan(s). I understand that Dr. Hariri IS NOT a MediCal or Covered California provider. I understand that all co-payments, deductibles, and/or non-covered services are to be paid in full at the time of service.
I hereby authorize the release of any information to my insurance company necessary to process the claims. I hereby authorize my insurance company to make payments directly to Dr. Hariri.
I authorize Dr. Hariri to check my medication history.

_____
Signature of Person Completing this Form Date
Relationship (if other than Patient): _____